JONES MEDICAL EQUIPMENT
481-B Elma G. Miles Parkway Hinesville, GA 31313 Phone 912-877-3202 Fax 912-877-3206
NPI 1578900841
210 Grand Central Blvd. Pooler, Ga. 31322 Phone 912-988-3718 Fax 912-988-7064
NPI 1396202495

*****ALL PHYSICIANS SCRIPTING FOR MEDICARE AND MEDICAID MUST BE PECOS CERTIFIED AND ENROLLED WITH GAMMIS. INFORMATION WILL BE VERIFIED DURING THE INTAKE PROCESS AND DENIED, IF YOU'RE NOT ENROLLED*****

CPAP and Supplies

Patient Name _____ DOB _____

Insurance _____ MBI # _____

Start Date _____ End Date _____

Treating Provider _____ NPI _____

Phone # _____ Fax # _____

Equipment Ordered (Circle All that Apply)

E0601- CPAP, Device, 1 Each

Name and SN of Machine Disp: _____

E0470- Bi-Level Assist Device w/out back up feature

Name and Lot # of Mask Disp: _____

E0471- Bi-Level Assist. Device w/Back-up feature

A9279- Download Option

E0562- Humidifier, 1Each

A7030- Full Face Mask Interface – QTY PER 3 MONTHS _____

A7031- Face Mask Cushion – QTY PER MONTH _____

A7032- Nasal Cushion – QTY PER MONTH _____

A7033- Nasal Pillow – QTY PER MONTH _____

A7034- Nasal Mask Interface – QTY PER 3 MONTHS _____

A7035- Head Gear – QTY PER 6 MONTHS _____

A7046- Water Chamber – QTY PER 6 MONTHS _____

A7036- Chin Strap – QTY PER MONTH _____

A7037- Standard Tubing – QTY PER 3 MONTHS _____

A7038- Disposable Filters – QTY PER MONTH _____

A7039- Non Disp. Filters – QTY PER 6 MONTHS _____

A7044- Oral Interface – QTY PER MONTH _____

A4604 Heated Tubing – QTY PER 6 MONTHS _____

To be completed by provider (must be signed by the ordering M.D.)

Prognosis (circle) Fair Good Poor Length of Need _____ (99= lifetime)

DX _____ ICD-10 Code _____

Indication- F2F Date prior to sleep test _____ Sleep Test Date _____

Date F2F clinical eval. by the treating physician after sleep test _____ F/UP _____

Has the patient had a qualifying sleep test that meets either of the following (circle all that apply):

a. The apnea-hypoxea index (AHI) or Respiratory Disturbance Index (RDI) is greater than or equal to 15 events per hour with a minimum of 30 events; or
b. The AHI or RDI is greater than or equal to 5 and less than or equal to 14 events per hour with a minimum of 10 events and documentation of :
    - Excessive daytime sleepiness, impaired cognition, mood disorders, or insomnia; or
    - Hypertension, ischemic heart disease or history or stroke.

By completing this form, I agree that I am the treating physician for this patient and understand that this patient must be complaint with use and physician visits. I agree to follow this patient CPAP therapy in conjunction with Jones Medical Equipment, per insurance guidelines and ensure the highest level of care is provided. Jones Medical Equipment, Hinesville agrees to do the same.

_____ _____

Physician Signature **Date**